

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5655

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05664

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Ellicott City		Balto City		3 Vol-4	
920 Schaeffertonwrelecent Home				1409 Cherry St.			
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH		(Month) (Day) (Year)
Female		JOSEPHINE		BALONIS	June 22		1955
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
Female		White		widowed		May 10, 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Home		Poland		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Jacob. Grocki		Boranski					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		18. MEDICAL CERTIFICATION	
No				Joseph Balonis 604 Washburn Ave			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X Immediate cause		(a) Bone brd hemorhage					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Hypokalemia Cu. chro					
		(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?							
Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
INJURY							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED OF INJURY m.		HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> At work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from June 17, 1955, to June 22, 1955, that I last saw the deceased alive on June 22, 1955, and that death occurred at 9A m., from the causes and on the date stated above. SIGNATURE: <i>Dr. Korkow. MD</i> ADDRESS: <i>Ellicott City</i> DATE SIGNED: <i>6/23/55</i>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
Burial		6/27/1955		Holy Cross		A. A. Co. Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-20-55		<i>J. H. Hedrick</i>		John J. Fialkowsky		2007 Eastern Ave	



## MARYLAND STATE DEPARTMENT OF HEALTH

65665

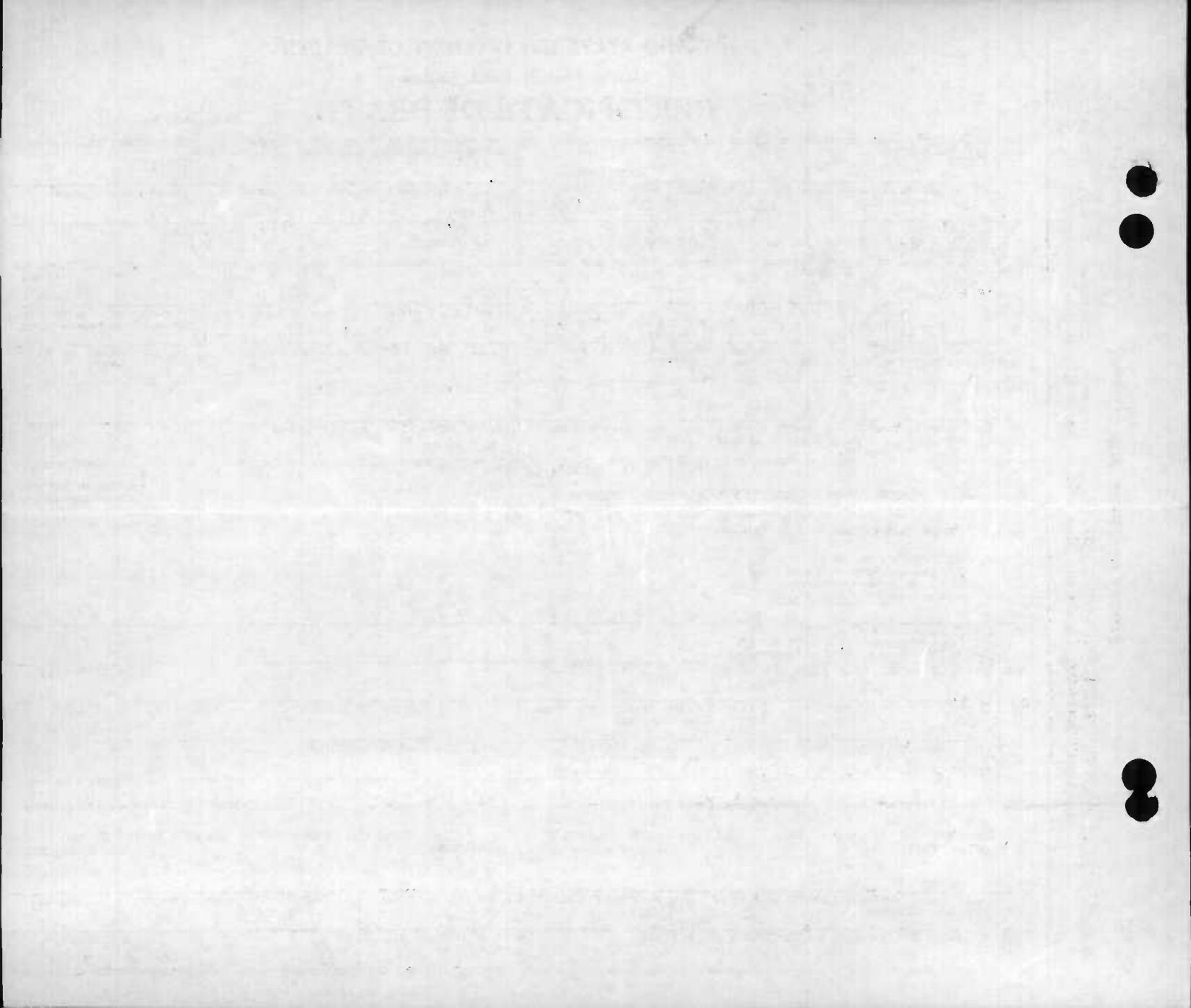
5656

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <i>Howard</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Baltimore</i>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Baltimore</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.D. &amp; ELLICOTT CITY</i>		STREET ADDRESS <i>2711 HURON ST</i>		
3. NAME OF DECEASED (Type or Print) <i>Eva</i>	(First)	(Middle) <i>A.</i>	(Last) <i>Berthold</i>	
SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>JAN 16 - 1892</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	9. AGE last birthday 63 yrs.	
13. FATHER'S NAME <i>Julius Wieprecht</i>	14. MOTHER'S MAIDEN NAME <i>-</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT AND ADDRESS <i>CHARLES E. Berthold 2711 Huron St</i>	12. CITIZEN OF WHAT COUNTRY?	
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
174X Immediate cause	(a) <i>Cardiac Failure</i>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last				
(b) <i>-</i>				
(c) <i>Carcinoma of Uterus</i>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>3/3/1955</i> , to <i>6/10/1955</i> , that I last saw the deceased alive on <i>6/10/1955</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.				
SIGNATURE <i>William F. Kavanaugh M.D.</i>	(Degree or title) <i>ADDRESS</i> <i>Albert St. Md.</i>	DATE SIGNED <i>6/10/55</i>		
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>6-14-1955</i>	NAME OF CEMETERY OR CREMATORIAL <i>Baltimore Park</i>	LOCATION (City, town, or county) <i>Baltimore</i>	(State)
DATE REC'D BY LOCAL REG. <i>8-13-55</i>	REGISTRAR'S SIGNATURE <i>Redick</i>	24. FUNERAL DIRECTOR <i>Porter B.M. Wallen</i>	ADDRESS <i>Franklin &amp; Stricker Sts</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5657  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. ....

I. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Howard MARYLAND		STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Ellicott City, Md.		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Schaffers Nursing Home		STREET ADDRESS (If rural, give location) 107 E. 25 TH. ST	
3. NAME OF DECEASED: (First) DANIEL (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) June 7 19 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH: 1-8-1871
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): OWNER		10b. KIND OF BUSINESS OR INDUSTRY: LUMBERMILL	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: unknown		14. MOTHER'S MAIDEN NAME: unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Preston S. Campbell 107 E. 25 ST. Balto. Md.			
18. MEDICAL CERTIFICATION Coronary Thrombosis			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  420.1 Immediate cause (a) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none			
19a. DATE OF OPERATION: none		19b. MAJOR FINDING OF OPERATION: —	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <i>George E. Burdorf</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 6-9-55 NAME OF CEMETERY OR CREMATORIAL Moreland Memorial Park LOCATION (City, town, or county) Balto. Md. (State)	
DATE REC'D BY LOCAL REG. 6.9.55		REGISTRAR'S SIGNATURE <i>John B. Langham</i> 24. FUNERAL DIRECTOR F.C. Higinbotham ADDRESS Ellicott City, Md.	

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JUN 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

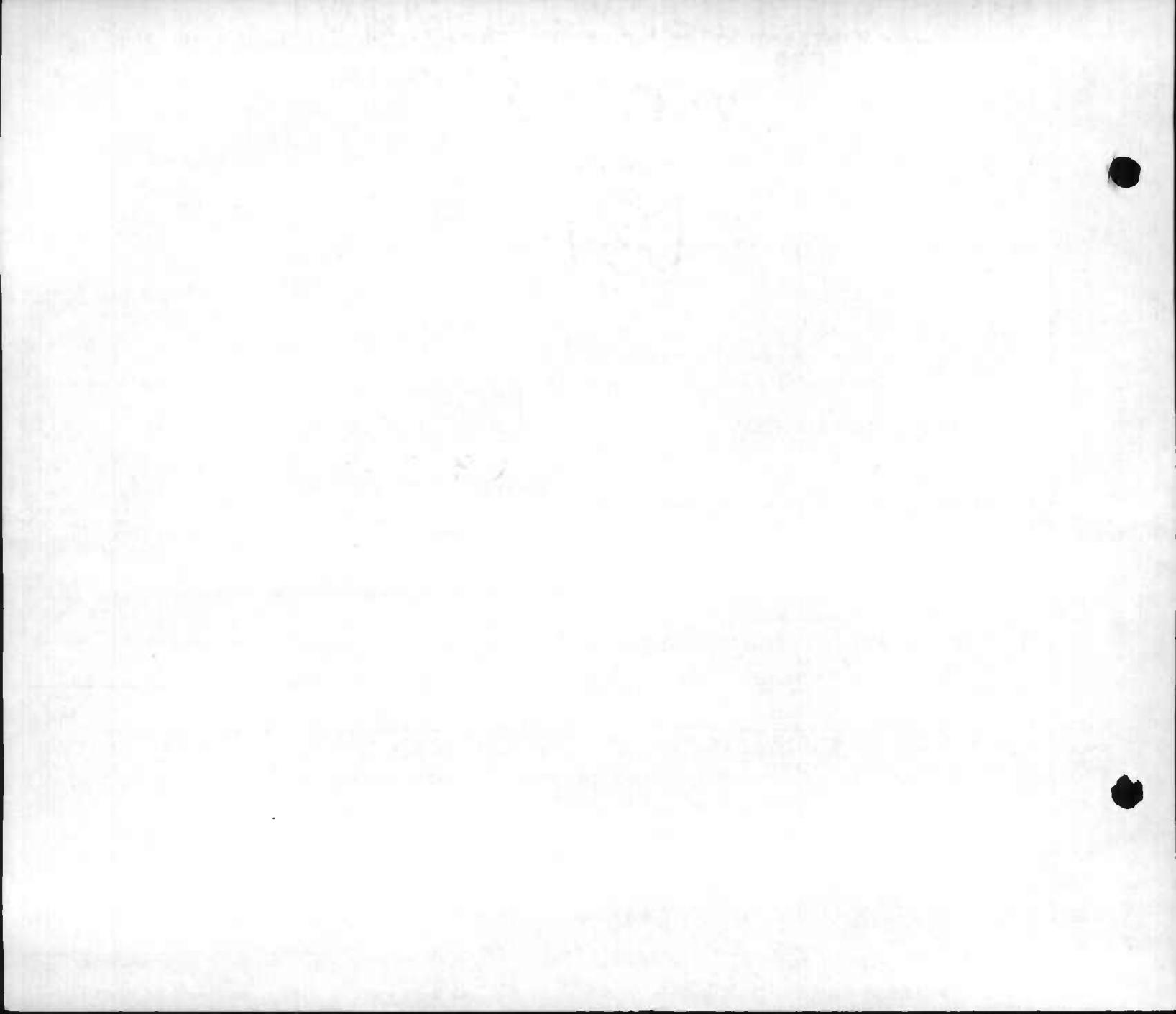
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05667

## CERTIFICATE OF DEATH

Reg. Dist. No. 196

1. PLACE OF DEATH: CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE CITY (If outside corporate limits, wrte RURAL and give nearest town) OR TOWN	
COUNTY Elliott City Howard County Maryland HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (in this place)	
X Elliott City		STREET ADDRESS	
90 Sheriff's Lodging House		Sudbrook Ave. ✓	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: June 21 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED. WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: July 2-8-1866
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY: United States	
13. FATHER'S NAME: Edward Barron		14. MOTHER'S MAIDEN NAME: Mary Kilcommons.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS: Balto. Co. Welfare Dept. Towson, Md.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs -	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE 422.1 ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) OUE TO Enterovirus C V disease			
(B) OUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1954, to June 4, 1955, that I last saw the deceased alive on June 4, 1955, and that death occurred at 8A M, from the causes and on the date stated above. SIGNATURE: S. A. Patterson			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: June 23, 1955	
DATE REC'D BY LOCAL REGISTRAR: 6-23-55		NAME OF CEMETERY OR CREMATORIAL: Daniel Ridge	
REGISTRAR'S SIGNATURE: A. W. Hedrick		LOCATION (City, town, or county): Edgewood S. End	
24. FUNERAL DIRECTOR: Daniel H. Newell-Peterson		ADDRESS:	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05669

Item 9 Film G183 7-5-55 et  
5659

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:  COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Ellisott City</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:  STATE <u>MD</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mariottsville</u> 03X-2 STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>Louis</u> (Middle) <u>-</u> (Last) <u>Chauss</u> (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 18 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>12-30-1861</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Agriculture</u>	
13. FATHER'S NAME: <u>Unknown</u>		11. BIRTHPLACE (State or foreign country): <u>France</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>None</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>McGeorge Chaus - Mariottsville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>177X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		18. MEDICAL CERTIFICATION (A) <u>Diarrhea &amp; Irritation with Intestines</u> DUE TO (B) _____ DUE TO (C) _____	
		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-16</u> , 19 <u>55</u> , to <u>6-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>55</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Ron B. Loughran</u> ADDRESS <u>Ellisott City and Johns</u> DATE SIGNED <u>6-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-21-55</u> NAME OF CEMETERY OR CREMATORIAL <u>Wards Chapel</u> LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-20-1955</u> JOHN B. LOUGHREAN, R.R. #1		24. FUNERAL DIRECTOR ADDRESS <u>Gilford H. Height - Gilfordville, Md.</u>	

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BUREAU U.S.

JUN 24 1955

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05670

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## CERTIFICATE OF DEATH

Reg. Dist. No.

195

M1mg183 7-7-55 et

## 1. PLACE OF DEATH:

COUNTY <i>Howard</i>	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)
TOWN <i>Laurel (Rural)</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>	

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE <i>Md</i>	COUNTY <i>Howard</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	STREET ADDRESS <i>Laurel (Rural)</i>
	(If rural give location)

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

4. DATE  
OF  
DEATH:*June 1 1955*

## 5. SEX:

6. COLOR OF  
RACE:*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):*Married*

## 8. DATE OF BIRTH:

*Unknown*

## 9. AGE last birthday:

IF UNDER 1 YEAR  
yrs. Months Days Hours Min.*70?*10a. USUAL OCCUPATION Give kind of  
work done during most of working life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:11. BIRTHPLACE (State or foreign country):  
12. CITIZEN OF WHAT  
COUNTRY?*Unknown*

## 13. FATHER'S NAME:

*Unknown*

## 14. MOTHER'S MAIDEN NAME:

*Unknown*15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

## 18. MEDICAL CERTIFICATION

## 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between  
Onset And Death

## Immediate cause

*Bronchial pneumonia**7 days*

## Antecedent causes (s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last.*Arteriosclerotic cardiovascular disease*

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?
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22. I hereby certify that I attended the deceased from <i>5/15 1955</i> , to <i>6-1, 1955</i> , that I last saw the deceased alive on <i>6-1, 1955</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.
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SIGNATURE (Degree or Title) *Frank P. Weaver* ADDRESS *Laurel, Md*DATE SIGNED *6-2-55*

23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
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DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
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<i>June 29, 1955</i>	<i>Dr. Frank P. Weaver</i>	<i>The Anatomy Board</i>	<i>Dr. M. Chester</i>
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BUREAU U. S.

JUN 29 1965

RECEIVED

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MARYLAND 5661

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH CITY (If outside corporate limits, write RURAL and give nearest town)		2. USUAL RESIDENCE (HOME) OF DECEASED CITY (If outside corporate limits, write RURAL and give nearest town)	
COUNTY <i>Howard</i>		COUNTY <i>Howard</i>	
TOWN <i>Cooksville</i>		STREET ADDRESS <i>Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>oo</i>		(If rural, give location) <i>Cooksville</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Louis</i>	(Middle) <i>William Henry</i>	4. DATE OF DEATH (Month) <i>June</i> (Day) <i>16</i> (Year) <i>1955</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9-6-1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Falcons</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Timber Co.</i>	9. AGE last birthday <i>64</i> yrs. If under 1 year Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
13. FATHER'S NAME <i>Louis W. H. France</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>Yes</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
(Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <i>705-12-2675</i>	
17. INFORMANT AND ADDRESS <i>M. Albert France, Cooksville, Md.</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p><i>443X</i>          Immediate cause (a) <i>Cardiac arrest, hypertension,</i></p> <p>Antecedent cause(s) (b) <i>Arteriosclerosis, arteria, left</i>  <i>hypertension.</i></p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Oct</i> , 1954, to <i>June</i> , 1955, that I last saw the deceased alive on <i>16 June</i> , 1955, and that death occurred at <i>7:15 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Howard E. Hall nos</i> ADDRESS <i>Dequerville, Md</i> DATE SIGNED <i>16 June 55</i>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE <i>6-19-55</i> NAME OF CEMETERY OR Crematory <i>Dorsey &amp; France family</i> LOCATION (City, town, or county) <i>Cooksville, Md</i> (State)	
DATE REC'D BY LOCAL REG. <i>June 18, 1955</i>		REGISTRAR'S SIGNATURE <i>C. Pearl Mercier</i> FUNERAL DIRECTOR <i>Edgar A. Haight - Dequerville, Md.</i> ADDRESS	

RECEIVED  
BUREAU V. S.  
JUL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death  
is especially important. Physicians: please write the causes of death clearly and legibly.

05673

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles Street, Baltimore  
**CERTIFICATE OF DEATH**

Reg. Dist. No. 191

1. PLACE OF DEATH. COUNTY Howard		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN ELLICOTT CITY		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Airy	
HOSPITAL OR INSTITUTION OR STREET ADDRESS OO		STREET ADDRESS 06X-2	
3. NAME OF DECEASED (Type or Print)	(First) ROSENE	(Middle)	(Last) MULLINIX
4. DATE OF DEATH .JUNE 19,	(Month) 1955	(Day)	(Year)
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH 10-9-1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Merson	14. MOTHER'S MAIDEN NAME Louise ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT AND ADDRESS Guerney Mullinix, Mt. Airy, Md.	
18. MEDICAL CERTIFICATION			
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u>          Immediate cause (a) <u>Tromoy occlusion</u>          Antecedent cause(s) (b) <u>Atherosclerotic cv disease</u>          Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last          (c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (CITY OR TOWN) (COUNTY) (COUNTY) (STATE) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While At work	HOW DID INJURY OCCUR? ADDRESS	
22. I hereby certify that I attended the deceased from <u>May 1, 1955</u> , to <u>June 19, 1955</u> , that I last saw the deceased alive on <u>June 18, 1955</u> , and that death occurred at <u>8 A.m.</u> , from the causes and on the date stated above. SIGNATURE <u>B. A. Kuhn</u> (Degree or title) ADDRESS <u>Ellicott City</u> DATE SIGNED <u>6/20/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 6-21-1955	NAME OF CEMETERY OR CREMATORIUM Montgomery Chapel	LOCATION (City, town, or county) (State) Montg. Co., Maryland
DATE REC'D BY LOCAL REG. 6-20-1955	REGISTRAR'S SIGNATURE John B. Longman	24. FUNERAL DIRECTOR C. M. Waltz, Winfield, Maryland	ADDRESS
Per. B. E. L.			

BUREAU Y.

JUN 24 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

5663

2411 N. Charles Street, Baltimore

05674

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH  
COUNTYCITY (If outside corporate limits, write RURAL and  
OR give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSMARYLAND  
LENGTH OF STAY  
(in this place)2. USUAL RESIDENCE (HOME) OF DECEASED  
STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWNSTREET  
ADDRESS3. NAME OF  
DECEASED  
(Type or Print)4. SEX  
Male5. COLOR OR RACE  
White6. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)8. KIND OF BUSINESS OR  
INDUSTRY9. DATE OF BIRTH  
11/5/188910. FATHER'S NAME  
William Henry Pannie11. BIRTHPLACE (State or foreign country)  
Montgomery Co.12. CITIZEN OF WHAT  
COUNTRY? U.S.A.13. MOTHER'S MAIDEN NAME  
Leatherman Anna Baithier14. INFORMANT AND ADDRESS  
Miss Ada E. Pannie15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Year, rank, or unknown) 191816. SOCIAL SECURITY NO.  
219-32-1034

## 17. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause  
(a) Coronary EmbolusAntecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

## (b) Chronic Myocarditis

## (c)

INTERVAL BETWEEN  
ONSET AND DEATH

1 hr.

2 yrs.

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE  
(Specify)PLACE (Home, farm, factory, street,  
OF office bldg., etc.)

## INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

## TIME (Month) (Day) (Year) (Hour)

OF  
INJURYINJURY OCCURRED  
While at Work  Not While At work 

## m.

## HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from Nov., 1953, to June 7, 1955, that I last saw the deceased

## alive on June 7, 1955, and that death occurred at 9 A.m., from the causes and on the date stated above.

SIGNATURE  
(Degree or title)

## ADDRESS

DATE SIGNED  
6/2/5523. BURIAL, CREMATION  
REMOVAL, (Specify)  
burialDATE THEREOF  
6-10-55NAME OF CEMETERY OR CREMATORIAL  
St. LouisLOCATION (City, town, or county)  
Clarksville, Md.

## (State)

DATE REC'D BY LOCAL  
REG.

## REG.

BUREAU V. S

JUN 13 1955

RECEIVED

05675

MARYLAND

5664

STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 195

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		Florida		Pinellas		
TOWN		6 days		STREET ADDRESS		(If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Balt. Wash. Blvd.		617 27th Ave. N.		48X-3		
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
5. SEX		6. COLOR OR RACE	7. SINGLED, MARRIED, WIDOWED, DIVORCED. (Specify)	Ranshaw	June	6		1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		July 4, 1883	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days Hours	If under 24 hrs Hours Min.
Housewife		own home		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	77 yrs.	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. INFORMANT AND ADDRESS		16. SOCIAL SECURITY NO.		
Joshua Griffith		Serelda Cobb		Wm J. Ranshaw St Petersburg Fla		617 27th Ave N		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.						

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH										18. MEDICAL CERTIFICATION	
420.1 Immediate cause										Acute Coronary Occlusion	
Antecedent cause(s)										10 min.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last										Arteriosclerotic, moderate with Coronary Insufficiency	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.										Old myocardial infarction (2)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		None		INTERVAL BETWEEN ONSET AND DEATH		15 yrs.			
None		None		None							
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.)		(CITY OR TOWN)		(COUNTY)			
None		None		None		None		(STATE)			
TIME (Month) OF INJURY		(Day)		(Year)		HOW DID INJURY OCCUR?		20. AUTOPSY?			
None						None		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

22. I hereby certify that I attended the deceased from 6/2, 1955, to 6/6, 1955, that I last saw the deceased

alive on 6/6/55, 1955, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county)		(State)	
Burial		June 9, 1955		Highland Cemetery		Conington		Kentucky	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
June 7 - 55		Frank Shifley		DeWitt		Laurel		Md.	

BUREAU Y. S

JUN 13 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

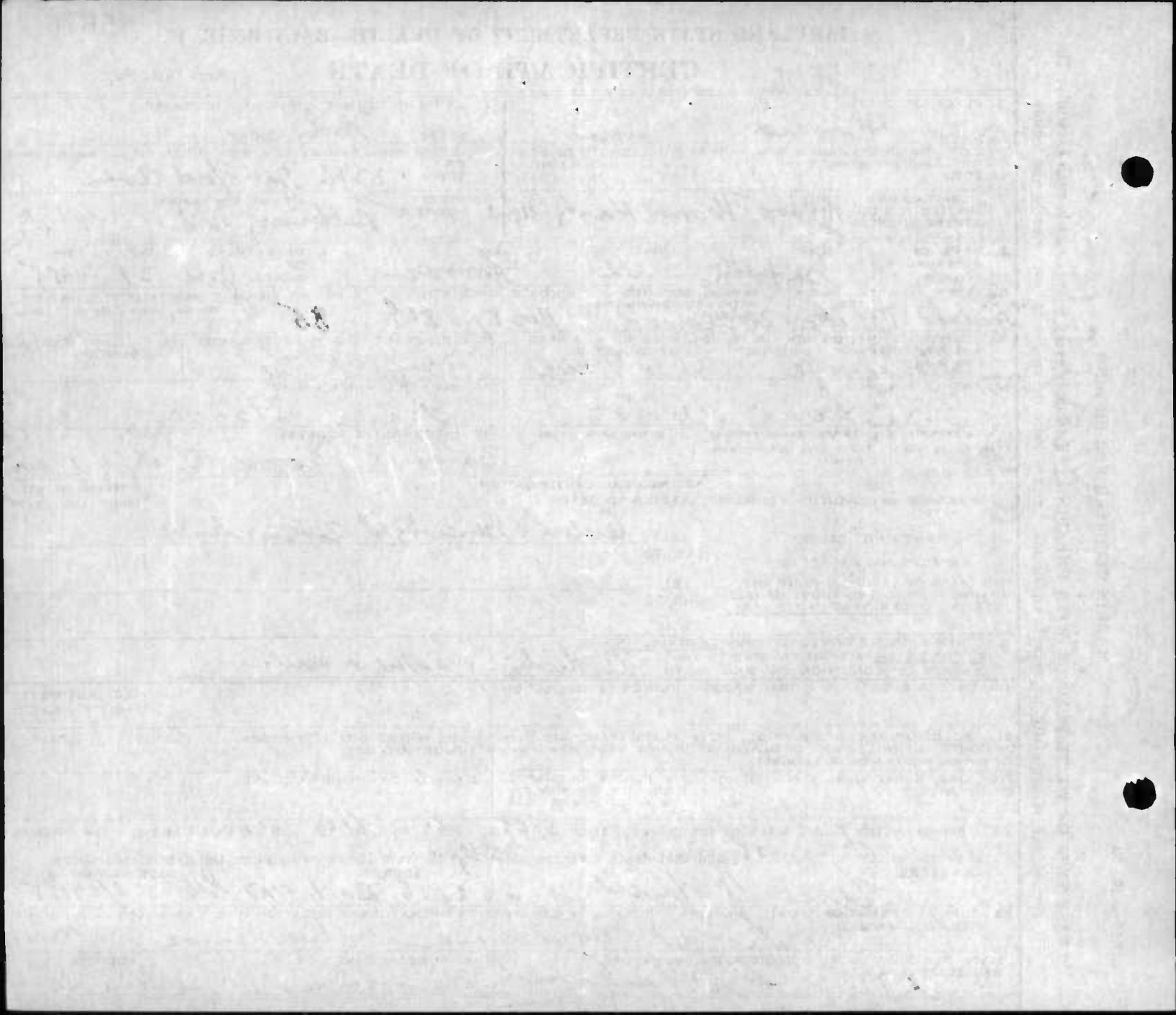
05676

5665

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town or town) <u>2746 Guilford Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hilltop Home Nursing Home</u>		STREET ADDRESS <u>Baltimore, Md 3801-4</u>	
3. NAME OF DECEASED: (First) <u>Seretude</u> (Middle) <u>Lee</u> (Last) <u>Thomas</u> (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 24 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 8, 1869</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
13. FATHER'S NAME: <u>Richard W. Lee</u>		11. BIRTHPLACE (State or foreign country): <u>Norfolk Va.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Ronney L. Thomas Guilford Ave 2746</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>334X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Cerebral &amp; Generalized Arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Anthrax of Spine &amp; Nerve</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/25</u> , 1955, to <u>6/24</u> , 1955, that I last saw the deceased alive on <u>6/22</u> , 1955, and that death occurred at <u>5:30 p.m.</u> from the causes and on the date stated above. SIGNATURE <u>Lucy J. Miller</u> ADDRESS <u>M.D. 5226 Bart. Nov. P. 16</u> DATE SIGNED <u>6/24/55</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>June 27-1955</u>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) <u>Woodland</u> <u>Baltimore</u> <u>md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/27/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.W. Geddes</u> <u>John Cook Jr.</u> <u>1217 St Paul St</u>	



MARYLAND

5665

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY Howard			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md.		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Ellicott City			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore		
HOSPITAL OR Scheaffers Retreat INSTITUTION OR 90 STREET ADDRESS Montgomery Road			STREET ADDRESS 4213 Connecticut Ave.		
3. NAME OF DECEASED (First) (Middle) (Type or Print) Mary or Mamie R. Williams			4. DATE OF DEATH June 23/55 (Month) (Day) (Year)		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Feb. 16, 1886	9. AGE last birthday 69	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Lady			10b. KIND OF BUSINESS OR INDUSTRY Jacobs Bros.		
13. FATHER'S NAME Wilson Palmer			11. BIRTHPLACE (State or foreign country) Stevensville, Md.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 212 05 7801		
17. INFORMANT AND ADDRESS Mrs. Louis Respass, 814 Woodington Rd			12. CITIZEN OF WHAT COUNTRY?		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  171X Immediate cause (a) <i>Barrenness of breast mouth ulcerative</i>			INTERVAL BETWEEN ONSET AND DEATH 2 years		
Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c) _____					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify) SUICIDE HOMICIDE			PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> m. <input type="checkbox"/>		
			HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, m., from the causes and on the date stated above. SIGNATURE <i>H. A. Shores</i>			ADDRESS <i>Baltimore</i> DATE SIGNED <i>6/24/55</i>		
23. BURIAL, CREMATION REMOVAL (Specify) Burial			DATE 6/27/55 NAME OF CEMETERY OR CREMATORIALoudon Park LOCATION (City, town, or county) Baltimore Md. (State)		
DATE REC'D BY LOCAL REG. June 25 1955			REG. R.W. 24. FUNERAL DIRECTOR ADDRESS Harry H. Witke 4101 Edmondson Ave		

05678

